

Diagnosing patients with tiredness in general practice

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Trying to sort out which patients have a relatively simple problem that will resolve spontaneously from those that require medical treatment and those that require urgent attention is one of the aspects of general practice that makes it interesting and challenging. Patients who present with tiredness in general practice can have any of a long list of diagnoses ranging from the trivial to the life threatening, and knowing how to determine who has which is an essential skill for competent practice. The study by Gialamas et al¹ (page 663 this issue) shows that of 342 patients who presented to general practitioners with tiredness as a symptom, 28 (8%) were diagnosed with a significant clinical diagnosis. Although 181 patients (53%) had at least one pathology test ordered, resulting in 1183 pathology tests, only 12 patients (4%) had a significant abnormality detected by pathology testing. The conclusion of the authors is that 'most tests do not yield a significant diagnosis'.

Does this mean that GPs caring for patients presenting with tiredness use pathology tests inappropriately? To know this, we would need to know much more about the possible causes of tiredness that might present in general practice, the ability of testing to contribute to the diagnosis and the potential consequences of testing versus not testing. To date, we have had little research in general practice to help us make such judgments. Would it help to use the Dutch College of General

Practitioners' strategy of delaying pathology testing for one month in patients with vague or nonspecific complaints of tiredness?² Again it depends on the possible diagnoses and the consequences of delaying a diagnosis in patients with vague symptoms.

One of my more memorable experiences as a GP was unexpectedly diagnosing Addison disease in a 45 year old woman who presented with vague symptoms of fatigue and amenorrhoea. Discovering that she was hyponatraemic was more good luck than good management, but this type of experience is one of the many reasons that doctors routinely order tests that are unlikely to contribute to patient management. The cost is the unanticipated abnormal result and we can rapidly become subject to a recently named syndrome, VOMIT (victims of modern imaging technology).³ The cure is more knowledge about whom and when to test.

There are some research initiatives making progress in this area. In 2002, the National Health and Medical Research Council awarded a program grant to researchers at the University of Sydney and the University of Queensland for research into diagnostic and screening tests (the Screening and Test Evaluation Program, <http://www.health.usyd.edu.au/research/step.html>). The grant includes funding for research on primary studies and systematic reviews of diagnostic and screening tests used in general practice and

methods for using these tests in practice. There is also an international collaboration of researchers who are performing research to assess the diagnostic validity of elements of the clinical examination: the Clinical Assessment of the Reliability of the Examination Group (<http://www.carestudy.com/CareStudy/Default.asp>).^{4,5}

Diagnosis in general practice will always be a challenge, but further research in these areas will help to reduce some of our current uncertainty.

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